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No. 00-

IN THE

Supreme Court of the United States

CHILDREN'S SEASHORE HOUSE,

Petitioner

v.

MICHELLE K. GUHL, Commissioner of the New Jersey Department of Human Services, And MARGARET A. MURRAY, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance,

Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Balanced Budget Act of 1997 eliminates the right of hospitals that qualify for supplemental Medicaid payments under §1923 of the Social Security Act ("Disproportionate Share Hospitals") to bring suit under 42 U.S.C. §1983 against state officials who refuse to make these payments.

RULE 14.1(b) STATEMENT

All parties are disclosed in the caption. No party to the case is a public company or an entity described by Rule 29.6.

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Children's Seashore House ("CSH") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra,* 5a) is reported at 197 F.3d 654 (3d Cir. 1999). The opinion of the district court (App., *infra,* 20a) is unreported.

JURISDICTION

The court of appeals entered its judgment on November 30, 1999. An order denying CSH's petition for rehearing and suggestion for rehearing en banc was entered on February 1, 2000. (App., *infra,* 1a) The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

42 U.S.C. §1983 provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

The relevant provisions of sections 1902(a) and 1923 of the Social Security Act, codified as amended, respectively, at 42 U.S.C. §1396a(a)(13)(A) and 42 U.S.C. §1396r-4, are reproduced, respectively, at App., *infra,* 33a and 34a-39a.

STATEMENT

This case raises the important question of whether hospitals that treat a "disproportionate share of indigent patients with special needs" may enforce the supplemental statutory reimbursement rights that Congress adopted for their especial benefit under §1923 of the Social Security Act (the "Act" or "Title XIX") in a suit based upon 42 U.S.C. §1983.

A. Statutory Background

Medicaid is a joint state/federal program that provides medical assistance to indigent persons. State participation in Medicaid is voluntary, but states that choose to participate must adhere to various federal requirements, including those which set parameters for payments to hospitals, as a condition of receiving federal financial participation. *See Harris v. McRae,* 448 U.S. 297 (1980). Federal standards governing inpatient reimbursement rates for "institutional" providers (i.e., hospitals and nursing homes) originally were contained exclusively within §1902(a)(13) of the Act. At the outset of the Medicaid program, this provision required retrospective, institution-specific "cost based" reimbursement.

In 1981, Congress amended this standard by enacting the "Boren Amendment." Pub. L. No. 97-35, 95 Stat. 808 (codified at 42 U.S.C. §1396(a)(13)(A)). The Boren Amendment required states to adopt institutional payment rates that are "reasonable and adequate to meet the costs" of "efficiently and economically operated" facilities that provide care and services in conformity with all state and federal standards, and to "assure" the Secretary of Health and Human Services (the "Secretary" of "HHS") that their rates satisfied this standard. *See generally, Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498 (1990) (*"Wilder"*). The Boren Amendment further required that, in adopting their standards and methods for setting Medicaid rates, states "take into account the situation of hospitals which serve a disproportionate share of low income patients with special needs." 42 U.S.C. §1396(a)(13)(A) (1981). Congress included this requirement out of concern that hospitals that treat high levels of indigent patients incur higher costs

than their peers and are more dependent on adequate Medicaid payments for their economic survival.[1]

Out of continuing concern for the economic viability of hospitals that treat a disproportionate number of indigent patients, Congress thereafter ordered the Secretary to report on the progress made in identifying and reimbursing DSH facilities. Consolidated Omnibus Reconciliation Act of 1985 §9519, Pub. L. No. 99-272, 100 Stat. 82. The Secretary's report revealed a "startling record of noncompliance" and a demonstration by many states of "indifference, if not hostility" towards this statutory obligation. H.R. Rep. No. 100-391, 100th Cong., 1st Sess. at 525 (1987). In response, in 1987 Congress added a new §1923 (Pub. L. No. 100-203 §4112, Pub. L. No. 100-360 §411(k)(6), codified at 42 U.S.C. §1396r-4) as a free-standing provision to the Act relating to DSH which severely limited the discretion of the Secretary and the states in this area.

Thus, under §1923(a)(1), 42 U.S.C. §1396r-4(a)(1), Congress specified that states "shall not be considered to meet the requirement" of §1902(a)(13)(A) unless those hospitals that qualify under standards contained in §1923(b) are qualified under their Medicaid State Plans as Medicaid DSH providers and provided with an "appropriate increase in the rate or amount of payment for . . . services provided by such hospitals" which is consistent with "subsection (c) of this section." §1923(a)(1)(B). In §1923(b), Congress mandated that hospitals satisfying either of two formulas relating to their ratio of indigent care will be "deemed" to be Medicaid dispropor-

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1. Congress included this provision because it found that such hospitals generally treat sicker and more costly patients than their peer institutions and are more dependent than their peers on adequate Medicaid reimbursement for their economic survival. *See* H.R. Rep. No. 97-208, 97th Cong., 1st Session at 962 (1981), *reprinted in* 1981 U.S.C.C.A.N. 1010, 1324 ("hospitals which serve a large Medicaid and low income population are particularly dependent upon Medicaid reimbursement"); S. Rep. No. 98-23, 98th Cong., 2nd Sess. (1983), *reprinted in* 1983 U.S.C.C.A.N. at 143, 194 ("Concern has been expressed [that]. . . hospitals [sic] which serve such patients may be more severely ill than average and that the DRG system [authorized by the 1980-81 amendments] may not adequately take into account such factors.")

tionate share hospitals.[2] In §1923(c) Congress set forth three alternative methods from which states must choose in setting appropriate supplemental payments for Medicaid DSH providers.[3]

B. Payments Made to CSH and The Balanced Budget Act Amendments

Petitioner CSH is a specialty hospital that provides acute rehabilitative care to pediatric patients, including infants and children with spinal or brain injuries or severe respiratory disease. Although it still maintains outpatient clinics in New Jersey, CSH relocated its inpatient hospital facility from Atlantic County, New Jersey, to Philadelphia, Pennsylvania in 1990. A substantial proportion of CSH patients are Medicaid recipients and other indigent children. CSH has at all relevant times been certified by its home state of Pennsylvania, in which it participates as a Medicaid provider, as a "deemed" DSH provider under §1923(b). As a result, CSH has regularly received from the Pennsylvania Medicaid agency a significant DSH percentage add-on to its regular per-case Medicaid fees for treating Pennsylvania Medicaid recipients.[4]

Medicaid recipients often receive care in states other than their domiciles, and CSH, by entering into provider agreements with that state, has also consistently participated in the New Jersey Medicaid program.[5] New Jersey, which borders

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2. *See infra,* 17 at fn. 13.

3. *See infra,* 18 at fn. 14.

4. Pennsylvania originally calculated DSH as a percentage adjustment to each "per diem" or "per discharge" fee paid to participating hospitals under Pennsylvania Medicaid's prospective payment system. *See* 55 Pa. Code §1163.67. Beginning in fiscal year 1995-96, Pennsylvania switched to an approach under which it maintained the same DSH judgment formula, but effectively aggregated the case-by-case adjustments and paid DSH adjustments to qualifying facilities on a quarterly basis.

5. This may occur when a patient is out of state and requires "emergency care" or "urgent care," where hospitals in bordering states provide services that are not locally available in the domicile state, or where border state hospitals voluntarily participate and serve patient populations in adjacent states. *See generally* 42 C.F.R. §431.52(b). Under rules promulgated by HCFA to implement 42 U.S.C. §1396a(a)(16), a Medicaid "State Plan must. . . pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if furnished to a recipient who is a resident of the State. . . ." *Id.*

Philadelphia, reimburses out-of-state hospitals that participate in its Medicaid program based upon the Medicaid rates used by those hospitals' home states. N.J.A.C. §10:52-4.4. The New Jersey Department of Human Services ("NJDHS"), which administers that state's Medicaid program, established base per diem Medicaid rates for CSH that were equivalent to Pennsylvania's. NJDHS derived those rates from CSH's Pennsylvania Medicaid rate notice.

Initially, New Jersey's official Medicaid State Plan specified that NJDHS would pay out-of-state hospitals on the basis of the basic Medicaid rates and DSH adjustments established by their home states. On June 30, 1997, NJDHS amended its Medicaid State Plan, specifically to provide that, effective retroactive to September 20, 1996, New Jersey would not pay DSH adjustments to participating hospitals located outside of New Jersey. App., *infra,* 7a. Although it paid CSH based upon its Pennsylvania base Medicaid rates, and although it pays DSH supplements to in-state hospitals that qualify under §1923(b) of the Act, NJDHS declined to recognize CSH's DSH status and refused to supplement the base payment with the percentage add-on that Pennsylvania's Medicaid agency had adopted for CSH under §1923(c) of the Act. Based upon Pennsylvania's DSH percentage formula, the DSH payments withheld from CSH by NJDHS amounted to approximately $2 million during fiscal years 1996 through 1999 (including approximately $780,000.00 in fiscal 1999).

C. The Action and Decisions Below

CSH instituted the action below against officials of NJDHS, acting in their official capacities, in the Federal District Court for the District of New Jersey to enforce its rights to receive the supplemental DSH payments required by §1923. CSH sought declaratory and injunctive relief pursuant to 42 U.S.C. §1983. In support of its claim, CSH alleged that New Jersey had deprived CSH of its right to equal protection of law under the 14th Amendment to the Constitution by paying facially discriminatory rates (i.e., denying DSH supplements) to qualifying out-of-state hospitals. (CSH later sought

leave to amend its complaint to assert an additional claim under the Commerce Clause.) CSH further alleged that, in failing to pay DSH adjustments, NJDHS also was violating sections 1902(a)(13)(A) and 1923 of the Act. In this regard, CSH relied, *inter alia,* on the decision in *West Virginia Univ. Hosps., Inc. v. Casey,* 885 F.2d 11 (3d Cir. 1989), *cert. denied,* 496 U.S. 936 (1990), aff'd *on other grounds,* 499 U.S. 83 (1991), holding that the Act mandates DSH payments to qualifying hospitals and does not recognize state borders as grounds for refusing to pay DSH adjustments. *See id.* at 29 ("[n]othing in §1396a(a) speaks in terms of a dichotomy in rate reimbursement built on state boundary lines").

After this action was filed, and *after* New Jersey amended its Medicaid State Plan to specify that it would not pay DSH supplements to participating hospitals located in other states, Congress amended the Medicaid statute through the Balanced Budget Act of 1997, Pub. L. No. 105-33 (the "BBA"). For State Plan Amendments adopted on or after October 1, 1997, the BBA amended §1902(a)(13)(A), 42 U.S.C. §1396a (a)(13)(A), to eliminate the Boren Amendment's "reasonable and adequate" rate touchstone and Secretarial "assurance" requirements in favor of a requirement that states must establish their base Medicaid rates pursuant to a "public process." 42 U.S.C. §1396a(a)(13)(A)(1997). In the BBA amendments Congress also inserted a new subsection §1902(a) (13)(A)(iv) which mandates that "state plans for medical assistance must" *continue* to include rates which take into account "the situation of" DSH providers "consistent with section 1923."

On September 25, 1998, defendants' predecessors moved to dismiss CSH's action for failure to state a claim upon which relief could be granted. The motion was grounded in the repeal of the former Boren Amendment, which this Court found to support a cause of action against the states under §1983 in *Wilder,* 496 U.S. 498. CSH contended that the BBA amendments had no impact on the pending action since §1923 of the Act, which includes the substantive requirements pertaining to payments to DSH providers, had not been repealed by the BBA amendments to Title XIX, and since §1902(a)(13)(A)(iv) continues to require states to comply with

§1923.[6] CSH further contended that the amendment of §1902(a)(13)(A) had no discernable bearing on the continued viability of its constitutional claim.

By order dated December 7, 1998, the district court dismissed the case, concluding that the Boren Amendment repeal eliminated petitioner's statutory and constitutional claims. *See* App., *infra,* 20a, 32a. On appeal, the Third Circuit reversed in part and affirmed in part. App., *infra,* 3a. The appeals court agreed with CSH that the BBA had no bearing on CSH's right to challenge a state's refusal to pay DSH adjustments to out-of-state hospitals under the Equal Protection clause. App., *infra,* 18a. However, the court of appeals affirmed the lower court's dismissal of CSH's claims predicated on §1923 of the Medicaid Act.

With little analysis or discussion, the court held that the repeal of the former Boren Amendment language eliminated the right of hospitals to sue under the Act and §1983 to redress the withholding of DSH adjustments. In response to petitioner's contention that the right to sue for DSH was centrally predicated on the provisions of §1923 of the Act—rather than on any of the provisions "repealed" by the BBA—the court stated: "We are satisfied that CSH cannot predicate its claim on these provisions." App., *infra,* 15a. The court of appeals acknowledged that various causes of action have been brought under §1983 and provisions of the Medicaid Act *other* than the Boren Amendment, but noted that "none of these cases was predicated upon the current version of" §1923, and that "these cases are all distinguishable from the current situation because each of them rested upon different provisions of the Medicaid Act." App., *infra,* 15a at fn. 3. Petitioner's application for rehearing and rehearing en banc was denied. App., *infra,* 1a.

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6. As noted below (*infra,* 13–14), the BBA actually fortified the rights of DSH providers under §1923 by obligating states to pay DSH adjustments directly to all qualifying hospitals for all services to Medicaid recipients on a "pass through" basis, even in situations where their Medicaid program is operated by managed care companies that are otherwise paid a "capitation fee" by the state to procure services from hospitals and other health care providers.

REASONS FOR GRANTING PETITION

Since 1981 Congress has repeatedly amended the Act to fortify the rights of those hospitals that treat a disproportionate share of indigent patients and effectively serve as the "Safety Net" providers for the Medicaid program. In the face of clear and unambiguous provisions of law designed to ensure specified levels of supplemental payments for such facilities, the Third Circuit has eviscerated their rights to enforce these protections through an action predicated on §1983. In so doing, the court below has created a clearcut conflict among the Circuits on an issue of great importance to a large number of hospitals.

In direct conflict with the Third Circuit, the Ninth Circuit held in *Children's Hosp. and Health Ctr v. Belse,* 188 F.3d 1090 (9th Cir. 1999), *petition for certiorari filed,* 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000) (No. 99-1497), that qualifying hospitals may continue to sue under the Act to challenge the denial of Medicaid DSH adjustments. Furthermore, in direct contrast with the approach taken by the Second Circuit and the decision below, the Ninth Circuit has squarely held in *Exeter Mem'l Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998), that all reimbursement provisions of State Plans adopted prior to the October 1997 BBA effective date — i.e., those adopted when the Boren Amendment language was still included in §1902(a)(13)(A) — remain subject to suit in an action brought under §1983 and §1902(a)(13)(A) of the Act. Accordingly, review by this Court is necessary to resolve a split among the circuits on the broader issue of whether the states remain subject to suit under *Wilder* if their Medicaid programs include ratesetting standards adopted before October 1, 1997.

Review is also warranted in light of the magnitude of the funding implicated by DSH adjustments and the importance of DSH funding to that class of hospitals that treats large uninsured and underinsured populations. DSH payments account for 1 out of every 11 dollars spent under the Medicaid program and the right to receive and assure receipt of these supplemental payments is crucial to those hospitals that bear the heaviest load of caring for indigent patient populations.

Finally, the Third Circuit's determination is also plainly incorrect. The court concluded that suits under §1923 were foreclosed on the basis that Congress had repealed the original Boren Amendment language. However, the lower court simply ignored the fact that Congress had "relocated" the statutory provisions detailing the states' obligations to make DSH payments from §1902(a)(B)(A) of the Act to §1923 of the Act in 1987, and specifically cross-referenced the states' continuing obligations to comply with §1923 in the recently amended version of §1902(a)(13)(A). The decision below also does not survive even a cursory analysis under the established test, illustrated in *Wilder* and in *Blessing v. Freestone,* 520 U.S. 329 (1997), for determining whether a § 1983 action will lie.

I. The Decision Below Creates a Compound Conflict Among the Circuits on Important Medicaid Reimbursement Issues

The decision below creates a two-level conflict among the circuits on important issues arising under Title XIX which should be resolved by this Court.

A. The Decision Below Creates a Conflict Among the Circuits as to Whether Hospitals May Continue to Seek Recourse Against the Denial of DSH Adjustments Under §1923

Even viewed narrowly, this case creates a conflict among the circuits concerning whether hospitals that qualify for Medicaid DSH adjustments were deprived by the BBA of the right to sue under §1983 to enforce their rights under §1923 of the Act. This Court recognized in *Wilder, supra,* that hospitals may sue persons under §1983 who, acting under color of state law, fail to pay or establish institutional Medicaid reimbursement rates in compliance with the standards of §1902(a)(13)(A). Those standards included the rights of participating hospitals to be paid appropriate rates "tak[ing] into account the situations of hospitals which serve a disproportionate number of low income patients." *West Virginia Univ. Hosp., Inc. v. Casey,* 701 F. Supp. 496 (M.D.Pa. 1988), *aff'd,* 885 F.2d 11 (3d Cir. 1989), *cert. denied,* 496 U.S. 936 (1990), *aff'd on other grounds,* 499 U.S. 83 (1991), which was decided

after the enactment of §1923, specifically upheld the rights of Medicaid hospitals to bring a §1983 action against a state that fails to pay DSH adjustments in accordance with federal law.[7]

Children's Hosp. and Health Ctr. v. Belshe, No. C-95-1076 MHP (N.D.C.A. Jan. 16, 1997), *aff'd*, 188 F.3d 1090 (9th Cir. 1999), *petition for certiorari filed*, 68 U.S.L.W. 3595 (Mar. 9, 2000) (No. 99-1497), recently held that the BBA did not affect the rights of hospitals to sue under §1983 to enforce the rights secured by sections 1902(a)(13)(A)(iv) and 1923 of the Act. In direct contrast with the Ninth Circuit's decision, the court below held that the BBA's repeal of the "reasonable and adequate" standard and "assurance" requirements imposed by the Boren Amendment deprived hospitals from "hav[ing] an enforceable statutory claim" under §1923. *See* App. *infra*, 14a-15a. As a result, hospitals located within the Third Circuit are hereafter deprived of the ability to challenge the denial of DSH payments under the very provisions of the Act which mandate those payments. Although hospitals may have still a limited right under the Third Circuit's ruling to contest the *interstate* denial of DSH in actions grounded in the Constitution, the decision below leaves no DSH provider with a meaningful right to protect its entitlement to DSH adjustments under the Act, and it deprives all such hospitals of the ability to seek relief against the unlawful withholding or underpayment of DSH adjustments by their own state. The conflict respecting the right of DSH hospitals to enforce a critically important provision of the Medicaid Act should be resolved by this Court.

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7. Like the case below, *West Virginia Univ. Hosps., Inc.* involved, *inter alia*, the refusal of a state (Pennsylvania) to pay DSH adjustments to a hospital that participated in its Medicaid program but was located in a bordering state (West Virginia University Hospital). As in the instant case, §1983 claims were advanced against the recalcitrant state under both the Equal Protection Clause of the Constitution and the Act. Finding that the Act itself was "border blind" and did not permit rate discrimination against out-of-state hospitals, *West Virginia Univ. Hosp., Inc.* granted relief under Title XIX, and did not find it necessary to reach the merits of the Equal Protection claim. 885 F.2d at 30 & n.9.

B. The Decision Below Widens A Conflict Among the Circuits on the Broader Question of Whether the BBA Amendment Precludes Boren Amendment Based Suits to Challenge Medicaid Rates Adopted Prior to the BBA Amendment

The decision below also widens a conflict among the circuits on the broader issue of whether the 1997 amendment to §1902(a)(13)(A) precludes suits under §1983 and *Wilder* with respect to Medicaid State Plan Amendments adopted prior to the effective date of the BBA. The lower court thus refused to recognize a §1983 action on behalf of CSH in view of the 1997 repeal of the Boren Amendment standards, notwithstanding that the discriminatory State Plan Amendment challenged by CSH was adopted in September 1996 — when the since repealed Boren Amendment standards were in force and effect.

In so ruling, the Third Circuit has aligned itself with the Second Circuit in *Hall v. Sullivan*, 129 F.3d 113 (2d Cir. 1997). There the court vacated a decision awarding institutional providers relief against rates alleged to violate the "reasonable and adequate" standards and dismissed the appeal as moot in view of the BBA amendments and the October 1, 1997 elimination of the "reasonable and adequate" rate requirement and "assurance" standard. *Accord HCMF Corp. v. Gilmore,* 26 F. Supp. 2d 873 (W.D.Va. 1998). In direct contrast, the Ninth Circuit held in *Exeter Mem'l Hosp. v. Belshe*, 145 F.3d 1106, that the BBA amendments had no impact on the rights of institutional providers to sue under §1983 for declaratory and injunctive relief against Medicaid rates or ratesetting standards or methods which failed to satisfy the Boren Amendment requirements under *Wilder* when they were promulgated. *Accord Florida Ass'n of Rehabilitation Facilities, Inc. v. Florida,* 47 F. Supp. 2d 1352 (S.D. Fla. 1999).

Resolution of this broader conflict is critically important to the administration of the Medicaid program. *At least* eighteen (18) states continue to utilize rates and ratesetting methods and standards for institutional providers that were included in Medicaid State Plan Amendments adopted prior to the October 1, 1997 effective date of the BBA amendment

of §1902(a)(13)(A).[8] Under the Ninth Circuit's approach, those states remain subject to suit under §1983 to the extent their Medicaid rates, or the procedures used for arriving at those rates, violate the now-repealed provisions of §1902(a)(13)(A). The opposite result obtains under the approach taken by the Second Circuit and the court below. This Court should grant certiorari to resolve this far reaching issue.

Additionally, the decision below is highly suspect under this Court's decision in *Landgraf v. USI Film Products,* 511 U.S. 244 (1994). *Landgraf* underscores the presumption that legal rights and responsibilities are to be determined under the law in effect at the time the operative acts occurred, not on the basis of after-enacted statutes. "When the intervening statute authorizes or affects the propriety of prospective relief, application of the new provision is not retroactive." *Id.* at 273. The view that pre-BBA State Plans prescribing institutional payment rates are still subject to a §1983 suit predicated on the Boren Amendment standards also finds support in the interpretations of the BBA issued by the Health Care Financing Administration of HHS ("HCFA"). In its implementing instructions, HCFA advised the states that the new public pro-

8. The Secretary does not currently maintain a centralized, comprehensive chronological catalogue of all State Plan Amendments, and a definitive evaluation of how many states maintain pre-BBA ratesetting methods for institutional providers would require the completion of a Freedom of Information Act request directed to each of ten (10) regional HHS offices. Counsel to CSH, however, reviewed the latest edition of the State Medicaid Charts published by the Commerce Clearing House ("CCH") *Medicare & Medicaid Guide*, which informally lists by date the latest State Plan Amendments filed by each state. This survey revealed that the following 18 states or territories had not amended *either* their long term care or their hospital state plan materials (both of which were subject to the Boren Amendment) since the effective date of the BBA: American Samoa; Washington, D.C.; Georgia; Guam; Idaho; Indiana; Iowa; Massachusetts; Montana; Nevada; New Hampshire; N. Mariana Islands; Puerto Rico; Tennessee; Utah; Washington; Wisconsin; Wyoming. The remaining states and territories may have amended either their long term care rates *or* their hospital rates since October 1, 1997 but not both. Accordingly, the number of states still subject to suit, in part, under the Ninth Circuit's approach, may substantially exceed 18.

cess approach governs State Plan Amendments adopted on or after October 1, 1997, but that the "repeal of the Boren Amendment cannot be interpreted to be retroactively effective." Guidance to State Medicaid Directors (Dec. 10, 1997). As the agency charged with administering the statute, HCFA's view — which is consistent with the Ninth Circuit's approach but contrary to that of the Second and Third Circuits — is entitled to deference. *Chevron USA, Inc. v. NRDC*, 467 U.S. 837 (1984); *Martin v. Occupational Safety and Health Review Comm'n*, 499 U.S. 144 (1991).

II. The Availability of Judicial Recourse to DSH Providers Under §1923 Is Socially and Financially Significant

The continuing availability of judicial recourse to DSH providers under §1923 presents a socially and financially significant issue. In requiring supplemental Medicaid payments for those hospitals that treat a disproportionate share of low income patients, Congress determined as a matter of legislative fact that this class of hospitals was vitally important to the delivery of care to Medicaid recipients and charity care patients, and that their provision of "disproportionate" amounts of care to government subsidized or "charity care" patients rendered these same institutions acutely vulnerable to Medicaid reimbursement shortfalls. *See infra.*, at fn. 1. Continued losses by DSH providers may cause such hospitals to limit or reduce services or to shut their doors.[9] In the case at bar, petitioner has alleged that whether or not it receives DSH adjustments determines whether or not it must lose money to extend care and treatment to Medicaid recipients. Accordingly, the very survival of many of these critical access health care providers, and the continued availability of care for large segments of the population, may turn on the hospitals' ability to enforce their rights to DSH payments that comply with §1923.

Moreover, the importance of being able to access DSH payments was heightened by provisions of the BBA. Under

9. As one consequence of Medicaid reimbursement reductions and the increasing penetration of managed care payers, CSH recently reduced its licensed inpatient bed complement.

§4701 of the BBA, Congress relaxed the ability of the states to adopt "mandatory" Medicaid managed care programs without obtaining special statutory "waivers" from HCFA.[10] Under §4721(d) of the BBA, Congress simultaneously enacted a new §1923(i), which obligates all state Medicaid programs to "carve out" the portion of their budgets earmarked for DSH adjustments from their "capitated" payments made to Medicaid managed care organizations, and to directly pay DSH adjustments established in accordance with §1923(c) to those hospitals. Just as Congress has buttressed the rights and protections afforded to DSH facilities, the decision below has removed the teeth from these protective measures of the BBA by declaring that DSH providers may no longer bring suit against state officials who violate §1923.

In addition to being critically important on an institution-specific basis, DSH payments implicate significant portions of state and federal budgets. A recent study[11] observes that DSH payments comprise approximately one out of every eleven dollars expended in the Medicaid program. According to the Government Accounting Office, Medicaid spending amounted to approximately $168 billion annually in fiscal year 1997. GAO Rept. 98-96 (Feb. 1998).

By limiting potential relief for DSH providers to claims against states that discriminate in their DSH payment policy on an interstate basis, the lower court has given a green light to states that—for budgetary or other reasons—may cease to make DSH pass-through payments to hospitals in their own

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10. Prior to the recent enactment of §1932 (BBA §4732(c)), states generally were required under §1902(a)(23)(A) of the Act, 42 U.S.C. §1396a(a)(23)(A), to assure Medicaid recipients the unrestricted choice of obtaining covered healthcare services from any participating provider. States could only divest recipients of this right—and thereby mandate that they receive healthcare services exclusively through a Medicaid managed care organization (such as an HMO) and its selective "network" of providers—by obtaining special "waivers" from the requirements of §1902(a)(23)(A) pursuant to §1115 or §1915(b) of the Act, 42 U.S.C. §§1315, 1396n. Subject to certain exceptions, §1932 authorizes the states to implement mandatory Medicaid managed care programs without such a waiver.

11. T. Coughlin, L. Ku, J. Kim, *Reforming the Medicaid Disproportionate Share Hospital Program in the 1990's* (Jan. 1, 2000) (Urban Institute).

states as required by §1923(i), or otherwise fail to pay DSH supplements that satisfy subsections 1923(b) or (c) of the Act. Plenary review by this Court is necessary to ensure that these important rights can be protected, and so that clear congressional intent to afford special protections to DSH facilities is not turned on is head.

III. The Decision Below Is Plainly Incorrect

Finally, review is warranted because the decision below is manifestly incorrect: there is no valid basis to conclude that §1923 of the Act does not support a claim for relief predicated on §1983. Indeed, petitioner respectfully submits that the conclusion that §1923 does not support a §1983 action is so far off the mark as to warrant summary reversal.

The court below determined that the repeal of the Boren standards formerly included in §1902(a)(13)(A) deprived CSH of the right to sue for DSH adjustments. That conclusion makes little sense in view of the simple fact that the rights CSH seeks to protect are secured by §1923. Not only was §1923 not repealed by the BBA, but §1902(a)(13)(A)(iv) was added by the BBA specifically to reaffirm the states' continuing obligation to abide by §1923, even under the revised rate-setting scheme. Section 1983 entitles an aggrieved entity like CSH to bring suit when persons act under color of state law to deprive it of any right served under federal law. Such rights are not limited to claims based on the Boren Amendment, but may include any provision of Title XIX capable of supporting an action under §1983 under the three-part test applied in *Wilder*.[12] Section 1923 is precisely such a provision.

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12. After having recognized the availability of a cause of action under §1983 for hospitals to enforce their Boren Amendments rights in *Wilder*, this Court applied a somewhat more restrictive test for recognizing a §1983 claim in *Suter v. Artist M*, 503 U.S. 347 (1992). Congress responded in 1994 by legislatively limiting the impact of *Suter* to actions arising under 42 U.S.C. §671(a)(15) through the enactment of Pub. L. No. 103-382, 42 U.S.C. §1320a-2 (1994). That provision relevantly states that a "provision [of the Social Security Act] is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State Plan or specifying the required contents of a State Plan." *See Harris v. James*, 883 F. Supp. 1511,

Without discussion or analysis, the Third Circuit summarily declared that "[w]e are satisfied that CSH cannot predicate its claim on ... [the] provisions of [§1923]" because, in the court's view, this section does not impose either a "substantive or procedural requirement" upon the states. App., *infra*, 15a. That conclusion cannot withstand a plain reading of §1923 or a straightforward application of the established test for ascertaining whether an action will lie under §1983. Under that test, a court must resolve the following three inquiries:

> (1) Did Congress intend the statutory provision in question to benefit the plaintiff?
>
> (2) Is the asserted right not so "vague and amorphous" that its enforcement would strain judicial competence?
>
> (3) Does the statute unambiguously impose a binding obligation on the States? In other words, [is] the provision giving rise to the asserted right couched in mandatory rather than precatory terms.

Blessing v. Freestone, 520 U.S. at 340-41. If these questions are answered affirmatively, a "rebuttable presumption" arises "that the right is enforceable under §1983." *Id.* That presumption can be overcome only in "exceptional cases" where "Congress itself... [makes] it clear that violation of a statute will not give rise to liability under §1983, either by express words or by providing a comprehensive enforcement scheme." *Livadas v. Bradshaw*, 512 U.S. 107 132-33 (1997).

NOTES *(Continued)*

1519 (M.D. Ala. 1995), *rev'd on other grounds*, 127 F.3d 993 (11th Cir. 1997). The lower courts have routinely upheld actions brought by Medicaid providers under §1983 to vindicate rights established for their benefit under a variety of provisions of the Act other than the Boren Amendment. *See e.g., Orthopeadic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998) (suit by hospitals under §1983 to enforce hospital outpatient payment provisions of §1902(a)(30)(A) of the Act, 42 U.S.C. §1396a(a)(30)(A)); *Rite Aid of Pennsylvania, Inc. v. Houston*, 171 F.3d 842 (3d Cir. 1999) (§1983 suit by pharmacies to enforce provisions of the Act relating to payment of reasonable pharmacy fees); *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998) (§1983 suit by recipients to enforce provisions of §1902(a)(8) of the Act, 42 U.S.C. §1396a(a)(8), requiring the "reasonably prompt provision of assistance").

Application of this test firmly establishes the presumption in CSH's favor. First, as the district court recognized (App., *infra*, 27a), there is no serious question that, as a federally qualifying DSH facility under §1923(b), CSH plainly is the intended beneficiary of sections 1902(a)(13)(A)(iv) and 1923. Indeed, the very basis for enacting the DSH provisions was "to assure that payment levels assist these [hospitals] in surviving the financial consequences of competition in the health care marketplace." H.R. Rep. No. 100-391, 100th Cong., 1st Sess. at 524 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-344.

Second, the right of qualifying hospitals to receive DSH payments plainly is not so "vague and amorphous" that its enforcement would "strain judicial competence." *Wilder* held that the courts were fully competent to determine whether a state had adopted a rate that is "reasonable and adequate" to cover the costs of "efficiently and economically operated" hospitals. Even though these standards were not defined either in the Act or regulations, the Court held that concepts of reasonableness and efficiency are a sufficiently "objective benchmark[ ]" for judicial enforcement. 496 U.S. at 519. The DSH standards are far more precisely defined than those found to be enforceable in *Wilder*. Under §1923(b), Congress included two mathematical formulas for identifying certain hospitals which—like CSH—are "deemed" to qualify for Medicaid supplemental DSH payments as a matter of federal law.[13] Under §1923(b) a State Plan is not in conformance with federal law unless the state adopts one of the three congressionally prescribed DSH payment methodologies set forth in §1923(c)(1),(2),(3), 42 U.S.C. §1396r-4(c)(1),(2),(3). Each of

13. These include hospitals with a "low-income utilization rate" (as defined by the Act) which "exceeds 25 percent," and hospitals that have a "Medicaid inpatient utilization rate (as defined in paragraph (2)) [that] is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving payments in the State" in which it is located. §1923(b)(1)(A),(B), 42 U.S.C. §1396r-4(b)(1)(A),(B). States must pay DSH adjustments to hospitals that qualify under either of these standards, but may also utilize more liberal standards under which additional hospitals can qualify for DSH at their election.

these three approaches is decidedly more specific than the "reasonable and adequate" standard.[14] Moreover, judicial enforcement of the DSH standards is further enhanced by interpretive guidance published by HCFA. *See* 55 Fed. Reg. 10077 (Mar. 19, 1990) (describing, *inter alia,* calculation of Medicaid DSH adjustments).

Third, the right to DSH payments under §1902(a)(13)(A)(iv) and §1923 is not merely "precatory." In the BBA Congress inserted a specific reference to paying DSH adjustments in §1902(a)(13)(A)(iv) in accordance with §1923. This is preceded by a mandate in the body of §1902(a)(13) that the states "must" provide DSH adjustments in order for their Medicaid State Plan to qualify for federal funding. At a minimum, those hospitals that, like CSH, satisfy the federal standards in §1923(b) *must* be classified as DSH facilities, and §1923(a) affirmatively obligates the states to pay to such hospitals DSH supplements that comport with §1923(c). As amended by the BBA, §1923(a)(1)(D) specifies that a "State plan under this subchapter shall not be considered to meet the requirements of section 1902(a)(13)(iv) unless" it complies with §1923 (c). 42 U.S.C. §1396r-4(a)(1)(D). Section 1923(a)(1)(B), 42 U.S.C. §1396r-4(a)(1)(B), mandates that states must pay an "appropriate increase in the rate or amount of payment for services provided by such [DSH] hospitals," which is further defined as one that "is consistent with subsection (c) of this

14. Two are mathematical formulas, and one relates to institution-specific costs. Each of the three alternatives allows the exercise of far less discretion by the states than did the Boren Amendment language. The first method requires a calculation of the exact amount of the adjustment to be paid to each DSH facility through use of the base rate multiplied by the hospital's "Medicare" DSH percentage. While the third statutory option under §1923(c)(3)(B), 42 U.S.C. §1396r-4(c)(3)(B) – which is inapplicable here—is less restrictively worded than the first two, HCFA narrowed that option through interpretative guidance that "[w]e do not believe the payment adjustment under the third option would differ significantly from the payment adjustments under the other two options specified in the statute." 55 Fed. Reg. 10077, 10081 (Mar. 19, 1990).

section." *Id.* Thus §1923 mandates actual payments to particular institutions *and* sets specific parameters for setting DSH adjustments.[15]

Nothing in the statute or legislative history rebuts the presumption that a DSH hospital may challenge a state's refusal to pay DSH adjustments under sections 1983 and 1923. To the contrary, Congress specifically enacted §1923 in order to *overcome* a record of "indifference, if not hostility of HCFA, and many of the States" to effecting DSH payments. *See 3, supra.* And, as noted, §1902(a)(13)(A)(iv) was added by the BBA specifically to mandate that each State Medicaid Plan must include rates which "in the case of hospitals, ... take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs."

Indeed, CSH's "presumptive" right to enforce compliance with §1923 under §1983 is further supported by the fact that Congress had proposed in earlier bills to repeal both the Boren Amendment's "reasonable and adequate" requirements *and* to amend the Act itself to expressly bar causes of action related to minimum payment rates. *See, e.g.,* H. R. 2491, 104th Cong., 1st Sess. (1995) §16002 (141 Cong. Rec. S16159-01 at S16247). In the final bill, Congress excluded provisions that would have barred future reimbursement suits by providers

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15. In *Wilder*, the Court inferred a "substantive" obligation for the states to pay "reasonable and adequate" rates from the procedural statutory mandate in §1902(a)(13)(A) that states must "assure" the Secretary that its rates satisfied these standards. 496 U.S. at 509-10. Sections 1902(a)(13)(A)(iv) and 1923 of the Act *directly mandate* the payment of rates that satisfy §1923(c) so that it is unnecessary even to have to "infer" a substantive right to DSH payments from a procedural requirement, as was the case in *Wilder*. Moreover, although States no longer are required under the amended §1902(a)(13)(A) to "assure" HCFA in writing of the "reasonableness and adequacy" of their inpatient hospitals rates, §1923(a)(2)(B), 42 U.S.C. §1396r-4(a)(2)(B), independently requires States to submit State Plan provisions describing their DSH "payment methodology" and reflecting "appropriate increases ... consistent with subsection (c)." *See* HCFA Notice, 63 Fed. Reg. at 54146 (Oct. 8, 1998) ("the Act *requires* the States to provide a description of the methodology it uses ... [which] *must* clarify that ... payments to [DSH] hospitals are made on the basis of the proportion of low-income and Medicaid patients served by such hospitals").

against the states and required the dismissal of pending suits not yet reduced to judgment. "Where Congress includes limiting language in an earlier version of a bill, but deletes it prior to enactment, it may be presumed that the limitation was not intended." *Russello v. United States,* 464 U.S. 16, 21 (1983) (citations omitted). *See Nachman Corp. v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 392-93 (1980). Consistently, the Conference Report on the final bill does not state that all suits under §1902(a)(13)(A) will be eliminated, or, for that matter, even reference a congressional intent to preclude suits under the revised §1902(a)(13)(A) pertaining to the State's compliance with the BBA's public notice process requirements. *See* H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. at 867-68 (1997).[16]

16. The trial court assumed that Congress "has foreclosed the possibility of private enforcement" of the DSH provisions based largely on the statement in H.R. Rep. No. 105-149 (1997) that "it is the Committee's intention that, following the [repeal of the Boren Amendment, the public notice process language] will not be interpreted as establishing a cause of action relative to the adequacy of the rates they receive." *See* App., *infra* 26a. This remark, however, is contained in H.R. Rep. No. 105-149, which accompanied a House Budget Committee version of the Bill that was never enacted as law. Committee pronouncements on unenacted laws are a dubious source of congressional intent. *See Lyons v. Ohio Adult Parole Auth.*, 105 F.3d 1063, 1070 (9th Cir.) *cert. denied* 520 U.S. 1224 (1997); 2A Sutherland Stat. Constr. 48.01 at p. 302. No similar language was included in the Conference Report. Moreover, the quoted language does not even relate to suits to enforce DSH rate standards determined under §1923. Rather, it speaks to the elimination of the suits to enforce the distinct provisions of §1902(a)(13)(A) mandating the payment of "reasonable and adequate" base inpatient hospital and nursing home rates. *Id.* H. R. Conf. Rep. No. 105-217.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5024

CHILDREN'S SEASHORE HOUSE,

Appellant

v.

WILLIAM WALDMAN, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES; KAREN SQUARRELL, ACTING DIRECTOR, OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE

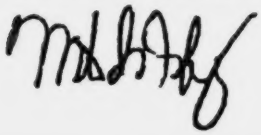
On Appeal from the United States District Court for the District of New Jersey (D.C. Civ. No. 98-02377)

SUR PETITION FOR REHEARING

BEFORE: BECKER, *Chief Judge,* and SLOVITER, MANSMANN, GREENBERG, SCIRICA, NYGAARD, ALITO, ROTH, MCKEE, RENDELL, and BARRY, *Circuit Judges*

The petition for rehearing filed by the appellant, Children's Seashore House, in the above captioned matter having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the court in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court en banc, the petition for rehearing is denied.

BY THE COURT:



Circuit Judge

DATED: FEB. 1, 2000

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5024

CHILDREN'S SEASHORE HOUSE,

Appellant

v.

WILLIAM WALDMAN, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES; KAREN SQUARRELL, ACTING DIRECTOR, OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

(D.C. No. 98-cv-02377)
District Judge: Honorable Anne E. Thompson

ARGUED BY COUNSEL
September 17, 1999

Present: Greenberg, Scirica and Rendell, *Circuit Judges*

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the District of New Jersey and was argued by counsel September 17, 1999.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court entered December 7, 1998, be, and the same is hereby affirmed to the extent that it dismissed plaintiffs statutory claims; reversed to the [sic] it dismissed the equal protection

claim and reversed and the cause is remanded to the said District Court for further proceedings consistent with the opinion of this Court. The parties will bear their own costs as to this appeal. All of the above in accordance with the opinion of this Court.

P. Douglas Sisk

ATTEST:
Clerk

Dated: November 30, 1999

Filed November 30, 1999

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5024

CHILDREN'S SEASHORE HOUSE,
Appellant

v.

WILLIAM WALDMAN, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES; KAREN SQUARRELL, ACTING DIRECTOR, OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE

On Appeal from the United States District Court
for the District of New Jersey
(D.C. Civ. No. 98-02377)
District Judge: Honorable Anne E. Thompson

Argued September 17, 1999

BEFORE: GREENBERG, SCIRICA, and RENDELL,
Circuit Judges

(Filed: November 30, 1999)

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OPINION OF THE COURT

GREENBERG, *Circuit Judge.*

I. STATEMENT OF THE CASE

Appellant, Children's Seashore House ("CSH"), a Philadelphia hospital that until 1990 had been located in Atlantic City, New Jersey, provides acute medical rehabilitation care to seriously injured or ill pediatric patients. CSH brought this action in the district court on May 8, 1998, seeking declaratory and injunctive relief to compel the New Jersey Department of Human Services to make disproportionate share hospital ("DSH") adjustments on account of CSH's treatment of Medicaid enrollees from New Jersey. In particular, CSH sued the commissioner of the Department and the director of its Division of Medical Assistance ("New Jersey") under 42 U.S.C. § 1983 in their official capacities to challenge New Jersey's amendment to

its Medicaid Plan effective September 20, 1996, which provides for the denial of DSH payments to hospitals located outside of New Jersey. CSH alleged that this policy violated CSH's rights under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* ("Medicaid Act"), and the Equal Protection Clause of the Fourteenth Amendment. New Jersey asserts that it had made the DSH payments to out-of-state hospitals until July 1, 1993, but that thereafter while it was contemplating the amendment's adoption, it discontinued the payments. CSH contends, however, that New Jersey never made DSH payments to it after it moved to Philadelphia.

On September 25, 1998, New Jersey filed a motion to dismiss or in the alternative for summary judgment. On November 9, 1998, CSH filed a motion, which the district court referred to a magistrate judge, to amend its complaint to assert a claim under the Commerce Clause. The district court then decided the case in an opinion dated December 7, 1998, in which it indicated that in its discretion it was determining the "matter as a motion to dismiss" which it granted. Of course, the district court therefore did not make a ruling on the motion for summary judgment, and neither the magistrate judge nor the district court ever ruled on CSH's motion to amend. CSH then appealed.

II. STATUTORY FRAMEWORK

In order that this matter be understood, we set forth the statutory background of the case. Medicaid is a joint federal-state program that provides for the payment of medical services pursuant to the Medicaid Act to the poor, elderly, and disabled. *See Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 845 (3d Cir. 1999). To participate, a state must submit a State Plan to the Secretary of Health and Human Services and obtain its approval of the plan detailing how the state will disburse Medicaid money. *Id.* at 846. A state may change its plan by obtaining approval of a State Plan Amendment. *Id.* The United States makes contributions to a state's program provided its plan is consistent with the applicable Medicaid Act provisions.

Beginning in 1981, Congress provided additional payments for disproportionate share hospitals, meaning

hospitals serving a high percentage of indigent patients. The two provisions regarding DSH adjustments relevant to this case are 42 U.S.C. § 1396a(a)(13)(A) ("a-13") and 42 U.S.C. § 1396r-4 ("r-4"). A-13 provides for a public process through which a state determines and sets reimbursement rates, while r-4 outlines the specifications regarding DSH adjustments. As it now reads a-13 states in its entirety:

> A State plan for medical assistance must —
>
> (13) provide —
>
> (A) *for a public process for determination of rates of payment* under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which —
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
>
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
>
> (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
>
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with [r-4]) the situation of hospitals which serve a disproportionate number of low-income patients with special needs . . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

When Congress adopted the current version of a-13 in the Balanced Budget Act of 1997 it repealed the following language, commonly known as the Boren Amendment, that stated:

> A State plan for medical assistance must —
>
> (13) provide —

> (A) *for payment* (except where the State agency is subject to an order under section 1396m of this title) *of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates* . . . which, in the case of hospitals . . . which serve a disproportionate number of low income patients with special needs . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . .

42 U.S.C. § 1396a(a)(13)(A) (West 1992) (repealed) (emphasis added).

Both the Boren Amendment and the 1997 amendment to a-13 are cross referenced with r-4. Thus, while r-4 continues to set the parameters for a state's provision of DSH adjustments, Congress in amending a-13 replaced the Boren Amendment's language requiring a state to pay "reasonable and adequate" rates with language mandating that a state provide a "public process" by which rates are determined in accordance with r-4. *See Children's Hosp. and Health Ctr. v. Belshe*, 188 F.3d 1090, 1094 (9th Cir. 1999).

A State Plan must provide for payment for covered services supplied by out-of-state hospitals to the state's own Medicaid program enrollees. *See* 42 U.S.C. § 1396a(a)(16); 42 C.F.R. § 431.52(b); *West Virginia Univ. Hosps. Inc. v. Casey*, 885 F.2d 11, 29 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83, 111 S.Ct. 1138 (1991). Moreover, it is clear that if Congress had not repealed the Boren Amendment in 1997, we would be bound to follow the holdings in *West Virginia v. Casey* that a state cannot set disproportionately low rates for out-of-state hospital services rendered — including DSH adjustments — for its Medicaid enrollees merely because the hospital is an out-of-state provider and that the out-of-state hospitals can enforce their rights to appropriate treatment. *Id.* at 17-22,

28-29; *see also Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 110 S.Ct. 2510 (1990). But inasmuch as we based *West Virginia v. Casey* on our conclusion that Pennsylvania's denial of adjustments to out-of-state hospitals violated the "reasonable and adequate" requirement of a-13 as it then existed, *see* 885 F.2d at 29, we now must determine whether Congress's removal of the "reasonable and adequate" language from a-13 requires a different result than that we reached in *West Virginia v. Casey*. Inasmuch as we conclude that the repeal of the Boren Amendment does require a result different from that in *West Virginia v. Casey* so that CSH cannot prevail on its direct statutory claim, we must decide whether its equal protection claim should have survived New Jersey's motion to dismiss.

III. THE DISTRICT COURT OPINION

As we stated above, the district court dismissed CSH's complaint on New Jersey's motion to dismiss pursuant to Rule 12(b)(6).[1] The court held that CSH lacks standing to bring its statutory claim because Congress intended to foreclose private enforcement of DSH adjustment payments when it repealed the Boren Amendment in 1997, and because r-4 itself did not confer standing on CSH. Applying the test the Supreme Court set forth in *Blessing v. Freestone*, 520 U.S. 329, 117 S.Ct. 1353 (1997), the court recognized that hospitals like CSH are the intended beneficiaries of r-4. The court reasoned, however, that while r-4 mandates that a state's Medicaid plan provide for an appropriate increase in Medicaid payments to DSHs based on specific rate adjustment procedures, unlike the Boren Amendment r-4 "does not mandate actual payment." Accordingly, the court held that r-4 "does not impose a binding obligation on New Jersey to actually afford CSH

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1. New Jersey indicated that it was moving to dismiss pursuant to Fed. R. Civ. P. 12(c). Rule 12(c), however, deals with motions for judgment on the pleadings. As a practical matter, however, in the context of this case there is no real distinction between the two types of motions. *See Churchill v. Star Enter.*, 183 F.3d 184, 190 n.5 (3d Cir. 1999). Thus, inasmuch as the district court treated the motion under Rule 12(b)(6) standards, we will as well.

payment, such that CSH has a federal right to payment under § 1983." Moreover, the court found that Congress's repeal of the Boren Amendment supported this conclusion as Congress eliminated the statutory provision mandating "reasonable and adequate" payment that had been regarded as conferring standing upon plaintiffs in the past. The court found its conclusions buttressed by statements of congressional intent to eliminate causes of action for hospitals and nursing facilities challenging the adequacy of the rates they receive.[2]

When the court addressed CSH's equal protection claim, it held that CSH could not maintain a valid claim because (1) the Medicaid Act does not "specifically" require states to fund out-of-state DSHs; (2) New Jersey was not treating CSH differently than it treated any other out-of-state hospital; and (3) the federal government had approved New Jersey's current Medicaid plan, including its policy not to provide for DSH adjustments to out-of-state hospitals, as conforming with Medicaid's requirements. Nevertheless, the court believed that its ruling was in tension with our rejection of what it called "Pennsylvania's alleged rational basis for excluding out of state hospitals from its Medicaid program" in *West Virginia v. Casey*, 885 F.2d at 29. But the court distinguished that case by pointing out that while "the West Virginia hospital which brought suit served an extremely high number of Pennsylvania residents," "[CSH's] complaint makes no such [equivalent] allegation. . . ." Accordingly, the court dismissed CSH's equal protection claim in addition to its statutory claim to enforce the Medicaid Act.

IV. DISCUSSION

CSH argues that the district court failed to recognize that r-4 authorizes actions to enforce DSH adjustments because r-4 delineates rights established by Congress for the specific benefit of DSHs and obligates the states to make supplemental payments to these hospitals. CSH contends

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2. The court also held that Medicaid's public notice provisions do not confer standing because they "are less than specific, mandatory requirements." CSH does not challenge this conclusion on this appeal.

that, in repealing the Boren Amendment, Congress did not repeal the requirement in r-4 mandating payment of adjustments to DSHs, but actually fortified the states' obligations to these providers. According to CSH, the court's assessment of the legislative history was erroneous, as the court relied upon statements concerning versions of the 1997 amendment to the Medicaid Act that Congress later changed and in any case did not address enforcement of the DSH provisions.

Additionally, CSH asserts that it has alleged a viable 42 U.S.C. § 1983 claim under the Equal Protection and Commerce Clauses. CSH contends that if viewed under either heightened or rational-basis scrutiny, the denial of benefits to hospitals based upon their domiciles violates both clauses. Finally, CSH contends that the district court's reliance on federal approval of New Jersey's plan cannot support its result.

We will affirm the district court's order dismissing CSH's statutory claim seeking to enforce the Medicaid Act with respect to DSH payments in light of the passage of the Balanced Budget Act of 1997 amending a-13. We, however, will reverse the order of dismissal to the extent that it dismissed the equal protection claim and will remand the case to the district court for further consideration of that claim as well as CSH's motion for leave to amend its complaint to assert a Commerce Clause claim.

A. *Standard of Review*

We exercise plenary review over the district court's order granting the motion to dismiss. *See McClintock v. Eichelberger*, 169 F.3d 812, 816 (3d Cir.), *cert. denied*, 120 S.Ct. 182 (1999). Furthermore, we must consider all factual allegations pled in the complaint as true and can affirm the district court's order of dismissal only if we are certain that CSH cannot prove any set of facts in support of its claim that would entitle it to relief. Moreover, regarding CSH's equal protection claim, "[s]ince this is a § 1983 action, [CSH is] entitled to relief if [its] complaint sufficiently alleges deprivation of any right secured by the Constitution. In considering a Rule 12(b)(6) motion, we do not inquire

whether [CSH] will ultimately prevail, only whether [it is] entitled to offer evidence to support [its] claims." *Nami v. Fauver*, 82 F.3d 63, 65 (3d Cir. 1996) (citations omitted).

B. *CHS's Statutory Claim to Enforce the Disproportionate Share Adjustments*

CSH argues that even if Congress's passage of the Balanced Budget Act of 1997 eliminated its ability under a-13 to enforce the DSH adjustments, nevertheless a court can enforce the adjustments under r-4. As noted above, the district court rejected this argument because it reasoned that r-4 does not impose a binding obligation on states to pay the adjustments. A-13 now mandates that a state provide for "a public process" for determination of rates. The process requires publication of the proposed rates together with the methodologies and justifications used to establish to those rates. Providers, beneficiaries, and other concerned state residents must be given a reasonable opportunity for review of and comment on the proposed rates, methodologies and justifications. Then the final rates, as well as methodologies and justifications for the rates, must be published. Finally, the rates must take into account the situation of DSHs in a manner consistent with r-4. *See* 42 U.S.C. § 1396a(a)(13)(A).

In *Blessing v. Freestone*, 520 U.S. at 340-41, 117 S.Ct. at 1359 (citations omitted), the Supreme Court said that a federal statute gives rise to a privately enforceable right if a court finds all three of the following circumstances present:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States.

We think it is clear that by amending a-13 in 1997, Congress eliminated the Boren Amendment's requirement that a state must provide for and assure the Secretary of Health and Human Services that its rates are "reasonable and adequate." As we recognized in *Rite Aid v. Houstoun*,

the Boren Amendment set procedural and substantive requirements: "The Boren Amendment instructed state agencies to make findings and assurances that their Medicaid reimbursement rates promote economy, efficiency, quality of care, and equal access. . . ." 171 F.3d at 852. Yet, by replacing the Boren Amendment with a requirement that a state establish a public process by which its rates would be determined, Congress has removed a party's ability to enforce any substantive right. *See HCMF Corp. v. Gilmore*, 26 F. Supp.2d 873, 880 (W.D. Va. 1998) ("With the repeal of the Boren Amendment nothing remains that remotely resembles a federal right to reasonable and adequate rates. There is no federal statutory language to parse. There is only a state standard. It follows that there can be no prospective relief under § 1396a(a)(13). . . .").

The legislative history confirms this reading of the statute. H.R. Conf. Rep. No. 105-217 (1997), *reprinted in* 1997 U.S.C.C.A.N. 176, 488, begins its discussion of the proposed change to a-13 with this description of the law under the Boren Amendment:

> Under so-called Boren amendments, states are required to pay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) rates that are 'reasonable and adequate' to cover the costs which must be incurred by 'efficiently and economically operated facilities.' A number of courts found that state systems failed to meet the test of 'reasonableness' and some states have had to increase payments to these providers.

The conference agreement, which became the new a-13, according to the report "[r]epeals the Boren amendments and establishes a public process under which proposed rates, methodologies underlying the rates and the justifications for such rates are published and subject to public review and comment, and final rates are published with underlying methodologies and justifications." *Id.* at 489.

Thus, unless r-4 establishes an enforceable right on its own, CSH does not have an enforceable statutory claim. Yet, r-4 imposes neither procedural nor substantive

requirements on a state that provide a basis for CSH to press its claims. Rather, r-4 is a definitional provision that describes certain procedures that a state must satisfy, such as submitting a qualifying plan to the Secretary of Health and Human Services by a certain date to establish an adequate state disproportionate share hospital adjustment plan. 42 U.S.C. § 1396r-4(a). Moreover, r-4 sets the parameters of what is a DSH, what constitutes an adequate payment adjustment, and what limits are placed on federal financial participation and on state allotments for each year. We are satisfied that CSH cannot predicate its claim on these provisions. For this reason, we will affirm the district court's dismissal of CSH's section 1983 statutory claim and its finding that CSH cannot successfully maintain an action to enforce the Medicaid Act with respect to DSH adjustments.[3]

C. *Equal Protection*

CSH claims that New Jersey's policy discriminates on its face against out-of-state hospitals in favor of domestic enterprises.[4] The Supreme Court has held that according to equal protection jurisprudence, "whatever the extent of a State's authority to exclude foreign corporations from doing business within its boundaries, that authority does not

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3. CSH cites *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 118 S.Ct. 684 (1998), *Rite Aid v. Houstoun*, 171 F.3d 842, and *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998), for the proposition that "[t]he Boren Amendment is only one of several provisions of the Medicaid Act on which providers have based § 1983 claims." Brief at 14. While this is true, none of these cases was predicated upon the current version of a-13 or upon r-4. Moreover, these cases are all distinguishable from the current situation because each of them rested upon different provisions of the Medicaid Act that "unlike r-4" have a substantive or procedural requirement.

4. CSH argues that this denial rises to the level of burdening a fundamental right and is therefore subject to strict scrutiny. However, inasmuch as CSH concentrates its argument upon a rational basis model of equal protection, we will as well. In any event, we have no need at this time to determine whether this is a strict scrutiny case because CSH's complaint survives a motion to dismiss in which only a rational basis justification is implicated.

justify imposition of more onerous taxes or other burdens on foreign corporations than those imposed on domestic corporations, unless the discrimination between foreign and domestic corporations bears a rational relation to a legitimate state purpose." *Metropolitan Life Ins. Co. v. Ward*, 470 U.S. 869, 875, 105 S.Ct. 1676, 1680 (1985) (internal quotation marks omitted).[5]

As we noted above, the district court rested its rejection of CSH's equal protection claim upon its belief that federal law does not require New Jersey to pay out-of-state hospitals because of federal approval of New Jersey's Medicaid plan including New Jersey's express statement that it would not provide for adjustments to out-of-state providers, and because the "current Medicaid statute does not specifically require States to fund DSH facilities outside their own borders." The court distinguished *West Virginia v. Casey* on the ground that "the West Virginia hospital which brought suit served an extremely high number of Pennsylvania residents." Moreover, the court thought that it was significant that New Jersey was not treating CSH differently than other hospitals outside of that state.

New Jersey in a supplemental letter brief urges that we affirm the district court's order dismissing the equal protection claim for the following reasons:

> First, New Jersey does not have sufficient information and data with which to determine whether an out-of-state hospital is entitled to DSH payments under the varying rules for making the determination. Indeed, as set forth in the State's main brief, any state can treat any hospital as a DSH hospital. Second, it would be an onerous task for New Jersey to monitor whether an out-of-state hospital has already been fully compensated by either its home state or other states[6] in

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5. Likewise, the courts consider discriminatory treatment based upon a citizen's state of residence a potential violation of the Privileges and Immunities Clause. *See Lunding v. New York Tax Appeals Tribunal*, 118 S.Ct. 766, 774 (1998) ("Where nonresidents are subject to different treatment, there must be reasonable ground for . . . diversity of treatment.") (internal quotation marks omitted).

6. This assumes that if all states were required to make DSH payments to out-of-state hospitals, other states may also be obligated to make DSH

accordance with 42 U.S.C. § 1396r-4(g), which limits the amount of DSH payments an individual hospital is entitled to receive.

Third, as now codified at 42 U.S.C. § 1396r-4(f), states' DSH allotments were changed so that set amounts are provided for each year beginning with Fiscal Year 1998. Clearly Congress reached a decision about how much each individual state was entitled to receive and there is no evidence that it considered, in its calculation, that a state may be required to give away significant portions of its DSH allotment to other states, particularly given the significant lobbying by the states which occurred prior to the final figures being enacted into law.

Fourth, this calculation is further complicated because it is not possible for New Jersey to anticipate where its residents may ultimately receive care. The statute either applies to out-of-state hospitals or it does not; there is no basis to limit DSH payments only to 'border' hospitals.

Fifth, once a hospital qualifies for a DSH payment, the hospital can use that money for any purpose, even non-medical purposes, because DSH payments are not payments for services provided. Nor would the hospital be required to even use the money received from New Jersey on New Jersey patients.

Lastly, out-of-state hospitals already receive DSH payments from the home state covering care provided to out-of-state residents. The home state is required to take into account treatment of out-of-state indigent patients when determining whether a hospital qualifies for DSH payments and how much DSH that hospital is entitled to receive.

Section 1923(b)(2) of the Act bases the Medicaid utilization rate on a formula that includes patient

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payments to a particular hospital. For example, a hospital could claim a DSH payment from any state as long as it treated at least one resident from that state. [This footnote is quoted from the letter brief.]

> days furnished to patients eligible for Medicaid . . . [t]he State must consider the total number of patient days attributable to Medicaid recipients *regardless of which state would be responsible for payment for the service. This is to ensure that each hospital that meets the . . . [DSH] requirement[s] is accorded disproportionate share status regardless of the origin of those patients. Id.* [55 Fed. Reg. at 10079 (emphasis added)].

It is unreasonable to conclude that Congress intended to have both other states and the home state count the same patient days, and reimburse for the same patient days. These six reasons for New Jersey's denial of out-of-state DSH payments more than satisfies the rational relationship test.

In our view, the district court's rationales cannot support a dismissal of the action. The absence of a provision in the Medicaid Act requiring that states fund DSH facilities outside their borders does not mean that a state constitutionally can differentiate between in-state and out-of-state facilities. Rather, it means simply that there is no statutory requirement for equal treatment. Furthermore, federal approval of the amendment to the plan at most could foreclose a statutory argument challenging the denial of DSH payments. Moreover, the fact that New Jersey treats all out-of-state facilities equally by denying them DSH payments does not address the issue CSH raises as it is complaining about its treatment as compared to treatment of New Jersey facilities, not as compared to treatment of other out-of-state facilities. In the circumstances, we cannot uphold the district court's reasoning on why CSH has failed to allege a claim on which relief can be granted on the equal protection claim.

Additionally, we cannot uphold the Rule 12(b)(6) dismissal on the basis of New Jersey's arguments that we quote above, as its contentions introduce matters into the case that go far beyond the complaint and even the pleadings as a whole and introduce factual questions which we cannot address at this time.[7] In short, we are not

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7. We realize that a court on a motion to dismiss can consider matters of public record, *see Churchill v. Star Enter.*, 183 F.3d 184, 190 n.5 (3d Cir. 1999), but New Jersey's contentions go beyond that record.

satisfied from the complaint or even all the pleadings that CSH will not be able to prove any set of facts that will entitle it to relief.

Accordingly, while we express no view on whether CSH ultimately will prevail on the equal protection claim, we think that the claim should have survived New Jersey's motion to dismiss. *See also West Virginia v. Casey*, 885 F.2d at 29 ("Pennsylvania's excuse of administrative burden does not, in this case, provide a rational basis for [the hospital's] grossly diminished reimbursement rates."). Therefore, we will remand the case to the district court for further proceedings on that claim. On the remand CSH may renew its motion to amend to assert its Commerce Clause claim.

V. CONCLUSION

For the foregoing reasons we will affirm the order of December 7, 1998, to the extent that it dismissed CSH's statutory claims but will reverse it to the extent that it dismissed the equal protection claim. We will remand the matter to the district court for further proceedings consistent with this decision. The parties will bear their own costs on this appeal.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

CHILDREN'S SEASHORE HOUSE, *Plaintiff,* v. WILLIAM WALDMAN, Commissioner, of the New Jersey Department of Human Services, and KAREN SQUARRELL, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance, *Defendants.*	**FILED** **DEC 07 1998** **AT 8:30 _M** WILLIAM T. WALSH CLERK Civil No. 98-2377 (AET) O P I N I O N

THOMPSON, Chief Justice

This matter is before the Court on the motion to dismiss by defendants William Waldman and Karen Squarrell, which was made on their behalf by the Attorney General for the State of New Jersey. The Court decided this motion after hearing oral argument on November 23, 1998. Although the parties have advanced various issues in their briefs, the sole issue in this motion is plaintiff's standing to sue for alleged violations of the Medicaid Act and the United States Constitution under 42 U.S.C. § 1983 ("Section 1983" or "1983"). For the reasons stated herein, defendants' motion will be GRANTED IN ITS ENTIRETY.

BACKGROUND

I. STATUTORY BACKGROUND

Medicaid is a joint federal-state program that pays for medical services provided to indigent persons who would otherwise be unable to afford such care, pursuant to provisions in Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et. seq,* ("Medicaid Act"). To participate, a State must submit a plan to the United States Secretary of Health and Human Services

which details how it will disburse Medicaid assistance, and the Secretary must approve the plan. Such a plan must meet a host of requirements. *See generally,* 42 U.S.C.A. § 1396a, 1396r-4. In short, the federal government matches the contributions of individual States where those States fund indigent healthcare programs consistent with federal Medicaid provisions.

Since 1981, Congress has enacted various provisions specifically addressing hospitals which serve a high percentage, or disproportionate, amount of indigent patients ("Disproportionate Share Hospitals" or "DSH"'s). *See e.g.* 42 U.S.C.A. § 1396a, 1396r-4. The additional subsidies are awarded based upon how many indigent patients a particular facility serves. Two specific portions of the Medicaid provisions relating to DSH facilities are at issue here: 42 U.S.C.A. 1396a(a)(13)(A) ("A-13") and 42 U.S.C.A. 1396r-4 ("R-4"). A-13 sets out a portion of the numerous requirements a State's Medicaid disbursement plan must satisfy before it may gain the federal government's approval. A-13 states:

> [a State's Medicaid plan *must* provide] for a *public process* for determination of rates of payment under the plan for hospital services, . . . under which—
>
> > (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
> >
> > (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
> >
> > (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

> *(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) [known here as R-4] the situation of hospitals which serve a disproportionate number of low-income patients with special needs*

[emphasis added]. Thus, A-13 states that R-4 outlines the specifications for how a State's Medicaid plan must fund DSH facilities. On August 5, 1997, Congress amended A-13. In making the 1997 amendment, Congress repealed, in pertinent part, the following language that was commonly known as the "Boren Amendment":

> [a State's Medicaid plan *must* provide] for *payment* . . . of the hospital services, . . . provided under the plan through the use of rates . . . which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . . [and) which the State finds, and makes assurances satisfactory to the Secretary, are *reasonable and adequate* to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws . . . .

[emphasis added]. The Boren Amendment language also included a cross reference to R-4, just as the present statute contains such a cross reference. Therefore, note that in changing the statute, Congress replaced various requirements, including the "reasonable and adequate" standard, with a "public process" requirement. However, further note that Congress left intact the cross reference to R-4 as a basis for determining payment rates for DSH facilities.

Briefly, along with other provisions, R-4 specifically defines DSH facilities by examining how many indigent patients a given hospital serves. *See* 42 U.S.C. 1396r-4(b). This examination does not require a State to determine the residence of indigent patients in calculating whether a given facil-

ity qualifies for DSH assistance. *See id.* Under 1396r-4(a), States' Medicaid disbursement plans must define which hospitals in a given State are DSH facilities using this definition, unless a given State can meet the exception in 1396-4(e), which allows a State to make DSH payments based on more general, aggregate calculations. Congress added the subsection (e) exception in 1998, the same year Congress enacted R-4 itself.

II. FACTUAL BACKGROUND

In May, 1998, plaintiff Children's Seashore House ("CHS") filed its complaint against William Waldman, the former Commissioner of the State of New Jersey's Department of Human Services, and Karen Squarrell, the former Acting Director of the Division of Medical Assistance and Health Services. Michele Guhl is the now the Commissioner and Margaret Murray is now the Director. The New Jersey Department of Human Services administers Medicaid and the New Jersey Division of Medical Assistance operates the program on a day to day basis.

In short, CHS is seeking declaratory and injunctive relief pursuant to Section 1983 based on an alleged wrongful failure to pay DSH subsidies under the Medicaid program. New Jersey's Medicaid program has changed on several occasions, both before and after Congress repealed the Boren Amendment.

It is uncontested that New Jersey stopped making DSH payments to out-of-state hospitals on or about July 1, 1993. *Defendants' Brief,* at 11.[1] However, it was not until June 30, 1997 that the federal government formally approved a Medicaid disbursement plan from New Jersey which specifically stated that New Jersey would not make DSH payments to out-of-state hospitals. *See id.* at 12. The plan containing this

1. Where plaintiff has not contested facts, and where those facts are not in conflict with facts the Court must accept as true, the Court will assume for the purposes of this motion that facts supplied by defendant are accurate.

provision is known as number 96-30B. *Id.* Note that when the federal government approved 96-30B, the Boren Amendment was still in effect, as it was not repealed until approximately one month later.

Although the parties have submitted briefs on various items, the sole issue ripe for review at this time is plaintiff's standing to bring suit under Section 1983. The parties are in disagreement regarding the applicable statutory framework for determining whether plaintiff CHS has standing. Plaintiff asserts that the Boren Amendment is applicable, since New Jersey first adopted 96-30B at a time when Boren was still in effect. In the alternative, plaintiff asserts that it has standing to bring its 1983 claim under either the current Medicaid statute, Medicaid regulations, or Equal Protection doctrines. The Court will address each of these assertions in turn.

In response, defendants assert that the current Medicaid provisions apply and that because the Boren Amendment has been repealed, it is an improper basis upon which to conclude that plaintiff has standing. Defendants further assert that plaintiff's remaining bases for standing are invalid, and that plaintiff's Equal Protection claim should be dismissed as defendants have articulated a legitimate reason for discontinuing DSH payments to out-of-state hospitals.

DISCUSSION

While defendants have filed this motion as a motion to dismiss pursuant to FED. R. CIV. P. 12(c), they have submitted affidavits in support of their motion, When making a determination under FED. R. CIV. P. 12(c), a court cannot consider matters outside the pleadings. When a party presents extraneous materials as part of his or her motion, or opposition thereto, a court has discretion to accept the extraneous material and convert the Rule 12(c) motion to one for summary judgment pursuant to FED. R. CIV. P. 56. *Wiley v. Hughes Capital Corp.*, 746 F. Supp. 1264, 1275 (D.N.J. 1990). In its discretion, the Court will decide the instant matter as a motion to dismiss.

Rule 12(c) provides in relevant part that "[a]fter the pleadings are closed but within such time as not to delay the trial, any party may move for judgment on the pleadings." In this situation, we apply the same legal standards as are used in considering a motion to dismiss under Rule 12(b)(6). *Turbe v. Government of Virgin Islands,* 938 F.2d 427, 428 (3d Cir. 1991).

The court cannot dismiss an action under Rule 12(b)(6) unless it appears beyond doubt that the plaintiff ran prove no set of facts in support of the claims as plead which would entitle the plaintiff to relief. *Conley v. Gibson,* 355 U.S. 41, 45-46 (1957). The factual allegations raised in the complaint must be assumed to be true. *Jenkins v. McKeithen,* 395 U.S. 411, 421 (1969); *Kost v. Kozakiewicz,* 1 F.3d 176, 183 (3d Cir. 1993). The complaint should be construed liberally in the plaintiff's favor, giving that party the benefit of all fair inferences which may be drawn from the allegations. *Wilson v. Rackmill,* 878 F.2d 772, 775 (3d Cir. 1989). "The issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Scheuer v. Rhodes,* 416 U.S. 232, 236 (1974).

PLAINTIFF'S STANDING TO BRING ITS § 1983 CLAIM

I. Boren Amendment (Repealed version of A-13)

Plaintiff first asserts that it has standing to bring its § 1983 claim under the repealed language of the Boren Amendment. Plaintiff further asserts that a standing analysis using Boren is appropriate because the Boren language was in effect when the federal government approved New Jersey Medicaid Plan number 96-30B, which formally discontinued medicaid payments from New Jersey to out-of-state hospitals.

Under Supreme Court precedent which is directly on point, it is clear that plaintiff would have standing if the Boren Amendment were applicable to this case. *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 516 (1989); *see also West Virginia Univ. Hosps. v. Casey,* 885 F.2d 11, 21 (3d Cir. 1989), *aff'd on other grounds,* 499 U.S. 83 (1991). However, given the fact that

Congress repealed the Boren Amendment precisely because its language has caused numerous lawsuits, this Court must conclude that Congress has foreclosed the possibility of private enforcement of the Boren Amendment. *See H.R. Rep. No. 105-149* (1997) (stating "it is the Committee's intention that, following the [repeal of the Boren Amendment, the public notice process language replacing that provision] will not be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive."); *H.R. Conf. Rep. No. 104-350* (1995) (stating "the Boren Amendment's vague payment standard resulted in numerous lawsuits . . ."). This Court will not ignore such a clear signal of Congressional intent. Defendants' motion to dismiss will be granted as to plaintiff's claims based on the Boren Amendment.

II. 42 U.S.C. 1396r-4 (Herein R-4)

Plaintiff contends that it has standing to bring its 1983 claims based on R-4. On the other hand, defendants assert that in repealing the Boren Amendment, Congress intended to foreclose hospitals' ability to bring 1983 suits, and moreover, defendants assert that there is no evidence suggesting that Congress intended the R-4 provision to replace the Boren Amendment as a basis for hospitals' 1983 claims. Both parties have cited *Blessing v. Freestone,* 520 U.S. 329 (1997) as the controlling Supreme Court decision for determining whether R-4 gives rise to plaintiff's right to sue under 1983.

Section 1983 allows private parties to bring suit to enforce certain rights conferred by federal statutes. *Maine v. Thiboutot,* 448 U.S. 1 (1980). Before a plaintiff may seek redress though 1983, however, a plaintiff must assert the violation of a federal *right,* not merely a violation of federal *law. Golden State Transit Corp. v. Los Angeles,* 493 U.S. 103, 106 (1989). *Blessing* set forth three factors Courts must use to determine whether a given federal statute gives rise to a federal right.

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the

> plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States.

520 U.S. at 340-41 (citing *Wright v. Roanoke Redevelopment and Housing Authority,* 479 U.S. 418, 430, 431-32 (1987)). If a plaintiff demonstrates that a federal statute creates an individual right, there is a rebuttable presumption that the right is enforceable under § 1983.

An examination of Congressional intent may rebut this presumption. Congress may expressly forbid recourse to § 1983 in the statute itself, or impliedly preclude 1983 suits by creating a broad enforcement scheme that is incompatible with individual § 1983 enforcement. *Id.* at 341. The Court will now analyze R-4 in light of *Blessing,* while focusing on the first and third factors.

Hospitals like CHS are the intended beneficiaries of the R-4 provision. *See Wilder,* 496 U.S. at 513; 42 U.S.C.A. 1396r-4. In conjunction with the current version of A-13, R-4 provides specific rules regarding DSH entitlements for hospitals serving a high proportion of indigent patients. The Court notes that A-13 now mandates that a "public process" provision regarding payments to DSH facilities must be included in a State's Medicaid disbursement plan, as opposed to Boren which required a provision for actual "payment". However, this language did not change the intended beneficiary of the R-4 provision, it merely changed what each State must include in its Medicaid disbursement plan.

The close question in this case is whether R-4 imposes a "binding obligation" on the States that gives rise to an enforceable obligation. In finding that the Boren Amendment imposed a binding obligation, the Supreme Court in *Wilder* focused on the fact that Boren *required* a State to provide some level of actual "payment" to healthcare providers. *See Wilder,* 496 U.S. at 512-13. R-4's language differs from Boren in this respect, since R-4 mandates that a State's Medicaid

plan define what it considers to be a DSH facility, and "provide" for an "appropriate" increase in Medicaid payments to such facilities based on specific rate adjustment procedures. R-4 does not mandate actual payment.

In light of this, and the legislative history given above regarding the repeal of the Boren Amendment, R-4 does not afford CHS standing in this case. R-4 does not impose a binding obligation on New Jersey to actually afford CHS payment, such that CHS has a federal right to payment under § 1983. Therefore, defendants' motion to dismiss will be granted to the extent plaintiffs standing relies on R-4.

III. MEDICAID PUBLIC NOTICE PROVISIONS

Plaintiff has also asserted it has standing to bring suit based upon Medicaid public notice provisions contained in 42 U.S.C.A. § 1396a(a)(13)(A)(i) and 42 C.F.R. § 447.205(c)(3). These provisions leave a great deal of discretion to the States as to how the notice will be published. As such, these provisions are less than specific, mandatory requirements. Instead, they are intended to give guidance to States regarding giving public notice when a State changes its medicaid plan. As such, these provisions are inadequate to create a federal right to sue under § 1983. *Suter v. Artist M.*, 503 U.S. 347, 361-62.[2] Plaintiff's claims based on the Medicaid public notice requirements will be dismissed.

IV. EQUAL PROTECTION

A successful Equal Protection claim "must show that the allegedly offensive categorization invidiously discriminates against the disfavored group." *Kranson v. Valley Crest Nursing Home*, 755 F.2d 46,52 (3d Cir. 1985) (citing *Price v. Cohen* 715 F.2d 87, 91 (3d Cir. 1983), *cert. denied*, 465 U.S. 1032 (1984); See also *Plyer v. Doe*, 457 U.S. 202,, 216 (1982), *reh'g denied*, 458 U.S. 1131. The level of scrutiny used by a reviewing court

2. The Court acknowledges that *Suter's* literal holding has been called into question by Congress. Nevertheless, it remains good law when read in the context of previous Supreme Court decisions.

depends on the classification of the group. In the absence of invidious classification, the government action will be sustained if it bears a rational relationship to a legitimate State interest. *Massachusetts Board of Retirement v. Murgia*, 427 U.S. 307, 312 (1976). Both parties agree that the "rational relationship" standard applies in this case.

Plaintiff has alleged that New Jersey's current Medicaid disbursement plan has wrongfully classified it as not being entitled to Medicare payments in violation of plaintiff's Equal Protection rights. Plaintiff has further alleged that this classification does not bear a rational relationship to a legitimate State interest. Moreover, plaintiff asserts that this Court must accept those allegations as true in considering this motion to dismiss.

The Court first notes that it need not take as true plaintiff's conclusory assertions regarding New Jersey's Medicaid disbursement plan. This Court is not required to accept conclusions which are void of factual or legal support. *See Schuylkill Energy Resources v. PP&L*, 113 F.3d 405, 417 (3d Cir. 1997); *Resolution Trust Corp. v. Farmer*, 823 F. Supp. 302, 305 (E.D. Pa. 1993). Moreover, in the context of this motion to dismiss, the Court may properly examine whether New Jersey's current Medicaid plan meets federal statutory requirements. *United Cerebral Palsy Assocs. of New York State, Inc. v. Cuomo*, 966 F. 2d 743, 744 (2d Cir. 1992) (examining legislative history in context of request for injunction for alleged Equal Protection violation); *Stengel v. Callaham*, 983 F. Supp. 1154, 1165 (N.D. Ill. 1997) (examining legislative history in context of motion to dismiss Equal Protection claim under Social Security Act).

It is undisputed that the federal government has approved New Jersey's current Medicaid plan as conforming with Medicaid's requirements. The current Medicaid statute does not specifically require States to fund DSH facilities outside their own borders. In addition, New Jersey is not treating CSH any differently than it treats other out of state hospitals. The Court is aware that the Third Circuit in *Casey* rejected Pennsylva-

nia's alleged rational basis for excluding out of state hospitals from its Medicaid program. *See* 885 F. 2d at 29. However, that ruling was restricted to the facts of that case, since the West Virginia hospital which brought suit served an extremely high number of Pennsylvania residents. *See id.* at 29. Plaintiffs complaint makes no such allegation and *Casey* is factually distinguishable on that basis. Therefore, the Court will find that New Jersey's current Medicaid disbursement plan does not violate the Equal Protection rights of plaintiff CSH and defendants' motion to dismiss will be granted as to that claim.

ABSTENTION

Defendants have asserted that this Court should abstain from hearing this case on the basis of the *Younger* abstention doctrine. In turn, plaintiff responds that there is no ongoing State judicial proceeding which would necessitate abstention. Since the Court agrees with plaintiff on this issue, the Court will not abstain on *Younger* grounds,

In *Younger v. Harris,* 401 U.S. 37 (1971), the Supreme Court announced an abstention doctrine preventing federal courts from interfering with pending State criminal prosecutions, even where there are allegations of constitutional violations and even though the federal court would otherwise have jurisdiction over the controversy. ERWIN CHEMERINSKY, FEDERAL JURISDICTION § 13.1 at 715-716. The *Younger* doctrine is based on federalism concerns, particularly the rationale of providing proper deference and respect to State judiciaries. *Id.* at 717. Since *Younger,* the Supreme Court has extended this doctrine to require federal courts to abstain from enjoining civil actions where the State is a party, as well as certain actions between private litigants if an important State interest is involved. *See e.g. Trainor v. Hernandez,* 431 U.S. 434 (1977); *Juidice v. Vail,* 430 U.S. 327 (1977). Federal court absention may also be merited under the *Younger* doctrine where there is a pending State administrative proceeding. *Middlesex County Ethics Committee v. Garden State Bar Association,* 457 U.S. 423 (1982).

Both parties agree that there has been some communication between plaintiff and the New Jersey officials responsible for allocating Medicaid assistance. However, nothing presented to this Court evidences a pending State administrative proceeding. Therefore, the Court will not abstain under Younger in this case.

CONCLUSION

For the foregoing reasons, defendants' motion to dismiss will be GRANTED IN ITS ENTIRETY and this case will be CLOSED. An appropriate Order is filed herewith.

Dated: December 7, 1998

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

CHILDREN'S SEASHORE HOUSE, Plaintiff, v. WILLIAM WALDMAN, Commissioner, of the New Jersey Department of Human Services and KAREN SQUARRELL, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance, Defendants.	:	Civil No. 98-2377 (AET) *ORDER*

THOMPSON, Chief Judge

For the reasons set forth in this Court's Opinion filed even date herewith;

It is on this 7th day of December 1998;

ORDERED that defendants' motion to dismiss shall be **GRANTED IN ITS ENTIRETY** and this case shall be **CLOSED**.

ANNE E. THOMPSON, U.S.D.J.

FILED
DEC 07 1998
AT 8:30 _M
WILLIAM T. WALSH
CLERK

42 USCA s 1396a
42 U.S.C.A. § 1396a

UNITED STATES CODE ANNOTATED
TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7—SOCIAL SECURITY
SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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Current through P.L. 106-170, approved 12-17-99

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * *

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

42 USCA s 1396r-4
42 U.S.C.A. § 1396r-4

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Current through P.L. 106-170, approved 12-17-99

§ 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section which meets the requirements of subsection (d) of this section), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c) of this section, effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f) of this section, effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this title shall not be considered to meet the requirements of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an

amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirements of subsection (d) of this section is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under

a State plan under this subchapter and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this subchapter).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1396b(w)(1)(A)(iii) of this title if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1396b(w)(4) of this title.

(c) Payment adjustment

Subject to subsections (f) and (g) of this section, in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind

described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in subsection (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a) of this section, the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) of this section (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in sub-

clause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) of this section to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2) (A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2) of this section) of not less than 1 percent.